STATE OF ARIZONA
NATUROPATHIC PHYSICIANS MEDICAL BOARD
1400 W. Washington #300 Phoenix, AZ. 85007
Phone Number: 602-542-8242 Fax Number 602-542-8804 Info@aznd.gov

APPLICATION FOR CERTIFICATE TO DISPENSE

Application Fee $150.00

Make Check Payable to: State of Arizona Naturopathic Medical Board **Mail to:** 1400 W. Washington, Ste 300 Phoenix AZ. 85007
If you are applying for a Certificate to Dispense at a not-for-profit organization/Public Health Facility, the fee of $150.00 is waived, however you are still required to submit a complete application form. **FEES ARE NONREFUNDABLE . Incomplete or unreadable applications will not be processed.**

ANY PHYSICIAN WHO SELLS NUTRITIONAL SUPPLEMENTS, HOMEOPATHIC MEDICATION, BOTANICAL MEDICATION, NON-PRESCRIPTION OR PRESCRIPTION-ONLY MEDICATION OR CONTROLLED SUBSTANCE TO A PATIENT IS REQUIRED BY LAW TO OBTAIN A CERTIFICATE TO DISPENSE FROM THIS BOARD.

Physician Name. _____ Medical License No._____

Email Address: _____

Primary Practice Location

_____ Suite #: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____

Secondary Location

_____ Suite #: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____

I am applying for a Certificate to Dispense at a ***not-for-profit*** *organization*. [ ]

Have you been issued a DEA Number by the United States Drug Enforcement Administration to dispense controlled substances?
NO [ ] YES [ ] **DEA Number**: _____

Has any complaint been filed or action been taken against you by any court or by any Federal or state agency for dispensing of any device, substance or drug? YES [ ] NO [ ]

If YES, on a separate sheet of paper attach to this application the following: list the name and address of the court, federal or the state agency in which the complaint was filed. Include Official Documentation of any action taken by the court, federal or the state agency. Include a complete explanation of events along with patient records.

I hereby attest to the Board that I am the physician named on this application form; the answers provided and any statement submitted with the renewal form is true and correct. Signature of licensee is required

_____ _____
Physician Signature **Date**

If a disabled person needs this application in an alternative format, please contact the Board office at (602) 542-8242, FAX (602) 542-8804, Voice Relay (800) 842-4681 or TDY (800) 367-8939